3. Hospitals qualifying under both formulae will receive only the Medicaid inpatient utilization adjustment.

4. Effective January 1, 1994, no hospital can be considered to be a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least one-percent.

C. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes.)
The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, and information from hospitals not participating in the Data Bank describing total patient days and Medicaid days. This information received by the department will be used to assure that all Colorado hospitals receiving Medicaid payments will be included in the calculation of disproportionate share amounts. Data Bank information will be subject to validation through the use of data from the department and the Colorado Foundation for Medical Care.

D. i. Effective July 1, 1993 Component 1 shall be superceded by a Disproportionate Share Adjustment payment method (herein described as Component la) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean. Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

ii. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado

Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

iii. For each hospital that qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be cost data published by the Colorado Indigent Care Programs in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The Colorado Indigent Care Programs costs, patient payments, and Program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit. Aggregate disproportionate share hospital payments will not exceed the published disproportionate share hospital limitations.

iv. Effective for the period from June 1, 1994 to June 30, 1994: each facility will receive a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program Patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered proportionately from all participating hospitals. The State will use historical data from the SFY 91/92 Colorado Indigent Care Program Annual Report to develop the prospective payment rate. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State, (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

v. Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

vi. Effective July 1, 1995, each facility will receive a Component Ia payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

vii. Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting

METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES-INPATIENT HOSPITAL SERVICES

The Medicaid inpatient utilization rate formula of one or more standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

viii. **Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of $93 million in Federal Fiscal Year 1998, and $85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).**

E. i. Effective July 1, 1994, an additional Disproportionate Share Adjustment payment method will apply to any outstate disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one standard deviation above the mean Medicaid

the Medicaid inpatient utilization rate formula of one or more standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

E. i. Effective July 1, 1994, an additional Disproportionate Share Adjustment payment method will apply to any outstate disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent. These hospitals do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition, and if they do, they are excluded from receiving this adjustment. Providers who are not participating in the Colorado Indigent Care Program are excluded from receiving this adjustment. Outstate hospitals are defined as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program.

ii. Effective February 26, 1997, an additional Disproportionate Share Adjustment payment method will apply to any specialty hospital meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent. These hospitals do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition, and if they do, they are excluded from receiving this adjustment. Providers currently participating in other disproportionate share refinancing programs, or who are not participating in the Colorado Indigent Care Program, are excluded from receiving this adjustment. Specialty Indigent Care Program providers are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population.

iii. These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is, an area outside of a Metropolitan Statistical area, as defined by the

Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21,1987.

iv. Hospitals must participate in the Colorado Indigent Care Program and must meet the separate annual audit requirements of the Colorado Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability, and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

v. Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care Program. These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

vi. For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon prospective data provided by the Colorado Indigent Care Program and will be paid in monthly installments. The basis for this calculation will be the projected reimbursement for the current fiscal year as calculated by the Colorado Indigent Care Program. The uncompensated cost for each hospital will be multiplied by no less than 20 percent to calculate the total reimbursement for Outstate Medically Indigent hospitals. The DSH payment will not exceed uncompensated costs as defined in the Social Security Act SEC.1923(g)(l)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program. A reconciliation will be done based on final financial data as calculated by the Colorado Indigent Care program.

9. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94. standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

10. Infant Cost Outlier. To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%, the Medicare rate) rather than to establish a separate cost outlier mechanism.

11. DRG Advisory Committee: A committee convened by the State Agency, consisting of Department representatives and representatives of the hospital industry to include, but not limited to:

    A. Representatives of urban facilities,

    B. Representatives of rural facilities,

    C. Representatives of rehabilitation and specialty-acute facilities,

    D. Representatives of facilities servicing relatively high percentages of Medicaid clients, and

    E. The Colorado Hospital Association

    The DRG Advisory Committee shall meet periodically, but no less frequently than annually, to provide advisory input to the State Agency on the DRG payment system. This input shall include, but not be limited to:

    A. Base rate calculation,

    B. Relative weight adjustment,

C. Changes in basic grouping methodology, or

D. Other aspects of the DRG payment system.

The State Agency will attempt to assure statewide geographic representation in the selection of committee members.

DRG Method of Payment:

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point, based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.

2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.

3. When approved outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG payment divided by the average length of stay. The percentage will be determined by the State Agency.

4. All State-operated facilities will be exempt from the DRG-based prospective payment system.

5. Abbreviated patient stays will be paid as follows:

   A. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

   B. In cases involving transfers, each hospital involved, excluding rehabilitation and specialty-acute hospitals, will be paid a DRG per diem for each case based upon the full DRG payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.

   C. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

Adjustments To The Payment Formula:

1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.

2. In order to continue to meet the Federal Boren Amendment requirements, the information used to calculate each prospective payment system (PPS) facility's cost per discharge will be updated. The following rebasing and payment protocol for payments is established:

   A. Effective September 19, 1990, the base rate for each facility shall be calculated based upon the most recently audited cost report available for each facility (as of 12/31/87). Changes made to audited cost reports after the rebasing calculations will not constitute the basis for a provider appeal. Fort the time period between July 1, 1990 and September 18, 1990, those hospital whose base rate increased by 7% or less as a result of the implementation of State Plan Amendment 90-02, should be assured a rate increase of at least 7% (not to exceed their FY 91 payment rate) during this 80 day period (July 1, 1990 to September 18, 1990).

   B. Beginning July, 1991, an annual inflator shall be applied to each facility's cost per discharge. This annual inflator shall be derived as follows:

      1. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.

      2. The HCFA Hospital Market Basket Index will be compared to the weighted average increase in the cost per discharge for each peer group. The weighted average increase will be determined by comparing the increase in costs from cost reports available for FYE 12/31/88. (In each subsequent fiscal year, the cost reports used for making the comparison shall be rolled forward by one year.)

      3. If the weighted average increase within each peer group in the cost per discharge is greater than the HCFA Hospital Market Basket Index, the difference between the figures will be added to the Market Basket Index to derive the annual inflator.